IF YOU ANSWER YES TO ANY QUESTIONS
PLEASE DO NOT ENTER THE POLLING AREA

SCREENING QUESTIONS

If you have symptom(s) that may be related to COVID-19 stay home and take care of yourself, please respect and protect your neighbors & our election workers & do NOT vote in person.

1. Have you developed ANY of the following symptoms of COVID-19 in the last ten (10) days:

FEVER (at or greater than 100 degrees Fahrenheit)
COUGH *(not related to chronic condition)*
Shortness of breath or difficulty BREATHING
Muscle or BODY ACHES or chills
New SINUS PAIN/ pressure
New LOSS OF TASTE OR SMELL
SORE THROAT
New CONGESTION or runny nose
(not related to allergies)
NAUSEA or vomiting
DIARRHEA

2. Have you or anyone in your household tested positive for COVID-19?

3. Have you or anyone in your household received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 14 days?

4 Have you/anyone in your household traveled outside the U.S. in the last 14 days?

5. Have you or anyone in your household traveled outside Massachusetts in the last 14 days?
Click here for details about Massachusetts Covid-19 Travel Order.
(State's listed on Low-Risk list are exempt.)

6. Have you or anyone in your household cared for an individual who is in quarantine or has tested positive for COVID-19?

7. Do you have any reason to believe you or anyone else in your household has been exposed to or acquired COVID-19?